introduction of the proforma stickers, showed that compliance rose to between 84-95% ($p<0.001$%paired t-test).
Conclusions: The WHO, BMA and RCS have all issued guidance on clinical handover but there is currently no structured protocol in place. Following the introduction of the European Working Time Directive a change in team working patterns has made safe handover of patients even more relevant. Our study demonstrates how a simple, flexible tool can significantly improve communication of core information to the weekend team.

1143: MULTI-STAGED REPAIR OF CONTAMINATED PRIMARY AND RECURRENT GIANT INCISIONAL HERNIAE IN THE SAME HOSPITAL ADMISSION: A PROPOSAL FOR A NEW APPROACH

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Background: Repair of contaminated primary and recurrent giant incisional herniae are extremely challenging. Literature supports the single & multi-staged approaches for these difficult patients.
Patients and Method: This is a prospective study of five patients treated by a new approach, not previously described. It is a multi-staged approach but in the same hospital admission, the first stage involves the eradication of contamination & the second stage is the definitive hernia repair with the new generation coated synthetic meshes.
Results: Of the five patients, three were men and two women with a mean age of 58 (45-74). Two patients had grade 4 while the remaining had grade 3 hernia as per the Hernia Grading System. All patients required extensive adhesiolysis, bowel resection and anastomoses and wash out. Hernial defect was measured as 204*(105-440) cm^2, size of mesh implant was 568*(375-930) cm^2 and the total duration of operation(1st + 2nd Stage) was 354*(270-540) minutes. Duration of hospital stay was 11*(7-19) days with a follow up of 17*(6-36) months.
Conclusion: Our multi-staged approach in the same hospital admission; excludes the disadvantages of a true multi-staged approach and simultaneously minimises the risks associated with a single-staged repair, hence leading to a successful outcome.

1162: DELAYED DISCHARGE IN DAY-CASE INGUINAL HERNIA AND GROIN REPAIR

Michael kelly [1], Thomas Reid [1], Prashant Singh [1], Michael Scott [2]. [1] *University of Liverpool, Liverpool, UK;* [2] *St.Helens and Knowsley NHS, St.Helens, UK.*
Aim: To assess both the rate and the reasons for delayed discharge in Day case inguinal hernia and groin repair in a busy consultant-led day-case unit over an 18 month period.
Method: Retrospective analysis of the records of 235 patients who underwent inguinal hernia/groin repair over an 18-month period took place.
Results: A total of 15 patients (6%) had a delayed discharge from day-case surgery over the time period. 11 cases of delayed discharge (73%) were attributed to poor post -operative recovery however there were 3 cases (20%) attributed to poor organisation on the part of the day-case unit. One case was unavoidable. (7%). Local Anaesthesia was utilised in 68 procedures (29%). The use of GA was associated with a significantly greater rate of delay in discharge compared to the LA mode of Anaesthesia (Fisher's Exact test $p=0.0411$).
Conclusions: An optimisation of anaesthetic technique in relation to the balance between post-operative pain control and nausea and vomiting as well as greater accuracy in patient selection and the organisation of day-case surgery could lead to a reduction in delayed discharge rate.

1187: AUDIT OF IV FLUID PRESCRIBING COMPARED TO GIFTASUP GUIDELINES

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Aims: Inappropriate IV fluid prescription causes significant morbidity in surgical patients. We audited compliance of fluid prescribing compared to Guidelines on IV Fluid Therapy for Adult Surgical Patients(GIFTASUP) in hospitals across our region.
Methods: All general surgical patients with a current complete fluid balance were eligible for inclusion. Patients undergoing acute fluid resuscitation or in renal failure were excluded. All fluid prescribed, fluid inputs and outputs, patients' weight, and blood results were recorded. Based on these measurements the daily replacement and maintenance requirement for fluid volume and electrolytes were calculated and compared with amounts given.
Results: Data collected for 221 patients across 11 hospitals. 75/221(34%) were prescribed the recommended maintenance fluid(1500-2500ml): range -3616ml to +6290ml. 14/221(6.3%) of patients were given recommended sodium maintenance(50-100mmol); range -525 to +821mmol. (6.8%) of patients were given recommended potassium maintenance(40-80 mmol), range -18.9 to +150mmol. 39 patients had serum $K^+<$ 3.5mmol/l, of which 11 received additional potassium.
Conclusions: Compliance with GIFTASUP fluid guidelines is poor across our region. There is poor compliance with recommended maintenance fluid volume prescription. There is almost universal excess Na^+ prescription and insufficient K^+ prescription. There is evidence that potassium electrolyte results are not taken into consideration when fluids are prescribed.

1236: HIRS: THE HIGHER RISK GENERAL SURGICAL PATIENT AUDIT OF NEW RECOMMENDATIONS FROM THE ROYAL COLLEGE OF SURGEONS OF ENGLAND AND DEPARTMENT OF HEALTH: IMPLICATIONS FOR CARE AT A LONDON DISTRICT GENERAL HOSPITAL

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Background: Two documents in the last year have highlighted the need for improvement in the care of the higher risk surgical patient (mortality more than 10%): the NCEPOD 2011 and the The Higher Risk General Surgical Patient (RCSEng and DoH guideline) with significant implications for service delivery. This audit assessed three of the key recommendations at Queen Elizabeth Hospital (QEH): 1. mortality risk calculation, 2. senior involvement and 3. place of peri-operative care.
Methods: A prospective case note review was carried out for all cases of major abdominal surgery at QEH in March 2012. Data was collected for 57 cases.
Results: There were 33 females and 24 males with an average age of 64. No cases had operatively mortality documented in the notes. 44% of cases were higher risk according the guideline 'patient score' with good correlation to the calculated P-POSSUM score. Almost half of these cases (49%) did not have a consultant surgeon present. Only 18% of these cases were admitted to HDU/ ITU post operatively.
Discussion: This audit has highlighted a number of areas for improvement in peri-operative care at QEH. Changes in practice will have significant resource implications for this trust and district general hospitals elsewhere.

1243: DOES NEUTROPHIL-LYMPHOCYTE RATIO PREDICT OUTCOME OF APPENDICECTOMY?

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Aim: Neutrophil-lymphocyte ratio (NLR) is a simple index of systemic inflammation and has emerged as a cheap and potentially valuable diagnostic and prognostic tool for various surgical conditions. We sought to investigate the predictive value of NLR for histologically positive acute appendicitis (AA) and the outcome of appendicectomy.
Methods: All patients undergoing appendicectomy for AA between January-December 2011 were retrospectively analysed. Patients were grouped according to NLR (<3.5=normal; ≥ 3.5=raised) and compared with length of hospital stay (LOS), surgical approach, post-operative complications, return to theatre, readmissions and histological outcome. Data were analysed using Mann-Whitney, Chi-square (X^2) and likelihood ratio (LR) analyses.
Results: 248 patients were identified (median age=30). NLR was significantly higher in patients with histologically positive AA ($p<0.001$). NLR ≥ 3.5 was predictive of correct diagnosis (positive LR=1.83; negative LR=0.36). Raised NLR was associated with increased incidence of post-operative complications ($X^2=6.13$;$p=0.013$) and return to theatre ($X^2=4.005$;$p=0.045$). NLR was not associated with LOS ($p=0.832$), conversion to open surgery ($X^2=1.346$; $p=0.246$) or need for readmission ($X^2=0.554$;$p=0.457$).
Discussion: Pre-operative NLR ≥ 3.5 is a predictor of histologically positive AA. Our study demonstrates poorer patient outcomes for those with NLR ≥ 3.5. Pre-operative NLR may represent a simple and valuable tool in this cohort and further validation is required.